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ABSTRACT

This paper addresses the current need for new, more effective ways of delivering mental health services. It recognizes the need for closer ties between mental health professionals and community groups, which has been met in the past by consultation and education (C and E) groups. But these groups have been hampered by complex social and organizational factors. This paper attempts to identify these obstacles and to examine their implications for the development and delivery of C and E services. It draws on relevant mental health literature, federal documents, and findings from an in-progress study of consultation and education units in four comprehensive community mental health centers (CMHC). Aimed at developing descriptive knowledge about C and E programs, it includes a review of archival records; field observations; and in-depth interviews with CMHC directors and program coordinators, C and E staff, and a purposive sample of direct service workers. (Author/BP)

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FACTORS AFFECTING THE DEVELOPMENT AND DELIVERY OF CONSULTATION AND EDUCATION SERVICES IN COMMUNITY MENTAL HEALTH CENTERS

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INTRODUCTION

Recent years have witnessed an increasing demand for new, more effective ways of delivering mental health services. Impetus for developing new approaches comes from a number of sources. First, it is generally recognized that there will never be enough professionals to meet current or future demands for direct service (Albee, 1967; Ochberg, 1976). Second, the cost of providing clinical services is prohibitively high, even when the duration of treatment is shortened. Third, when people experience problems they frequently turn to friends and lay helpers before turning to mental health professionals (Gurin, Veroff, and Feld, 1960; Scarlett, 1970). Finally, the emergence of self-help groups as a force in society raises questions about how professionals can more effectively collaborate with natural helping systems (Borkman, 1976; Collins and Pancoast, 1976; Durman, 1976).

Taken together, these forces provide a rationale for developing closer ties between mental health professionals and community groups. Ironically, community mental health centers (CMHCs) have pursued this goal for more than a decade through the provision of consultation and education (C&E) services; yet there is increasing evidence that the development of C&E services has been hampered by complex social and organizational factors (Broskowski and Baker, 1974; Cherniss, 1977; Ketterer and Bader, 1977; Perlmutter, 1973; and Snow and Newton, 1976). Now, with renewed interest in C&E, it is important to identify these obstacles and to examine their implications for the development and delivery of C&E services.

In approaching this task, the present paper draws on relevant mental health literature, federal documents, and findings from an in-progress study of consultation and education units in four comprehensive CMHCs (Ketterer and Perkins, 1977; Bader and Dade, 1977; Ketterer and Bader, 1977). This

study, aimed at developing descriptive knowledge about C&E programs, includes a review of archival records, field observations, and in-depth interviews with CMHC directors and program coordinators, C&E staff, and a purposive sample of direct service workers.

MACRO-ENVIRONMENT: SOCIO-POLITICAL FACTORS

C&E programs are affected not only by organizational and interpersonal factors, but also by factors in the macro environment. Macro-environmental factors refer to socio-political variables which underlie mental health policy and shape the direction of services. Three of these variables have a critical impact on C&E services: (1) the dominance of the medical paradigm; (2) the lack of sufficient manpower trained in an alternative paradigm; and (3) the inadequacy of federal guidelines and financial support for C&E programs.

The Medical Paradigm and the Search for an Alternative

According to Kuhn (1970), the noted philosopher of science, a paradigm refers to a disciplinary matrix consisting of definitions, values, and practices shared by members of a specific community (pp. 181-187). Kuhn argues that paradigms are never disproven but are gradually displaced as alternative paradigms emerge.

During the last century the medical paradigm has been the dominant perspective in the field of mental health (Szasz, 1960, 1970; Greenblatt and Levinson, 1965). This paradigm consists of four related characteristics. To begin with, it reflects belief in the "structural parallelism between the onset, nature, and treatment of psychological and physical dysfunction" (Cowen, 1973, p.429). This belief leads to the search for narrow or unitary causes of mental disorders, rather than the identification of complex

systemic factors (Broskowski and Baker, 1974). Second, the medical paradigm is directed toward identified clients and uses treatment techniques designed to ameliorate existing disorders rather than to prevent them from occurring. Third, it employs a "waiting mode" of service delivery in which an expert diagnoses and treats clients from an office, hospital, or clinic rather than providing services in the community (Rappaport and Chinsky, 1974). Finally, the medical approach focuses on changing or resocializing individuals, not on altering social, political, or economic systems.

Although the medical paradigm continues to dominate the mental health field,[1] in recent years a social/community (SC) paradigm has arisen to challenge it (Cowen, 1973; Rappaport, 1977; Heller and Monahan, 1977; Kelly, 1968). In essence, the SC paradigm rejects the idea that mental disorders result from a unitary cause, posing instead a multiple risk theory (Price, 1974) that examines the interaction between individual variables and environmental factors such as the predictability of one's environment, the amount of one's "turf control," and the availability of social supports in times of stress (Broskowski and Baker, 1974; Cassel, 1971, 1973; Caplan, 1974).

Second, the SC paradigm avoids the client centered approach characteristic of the dominant perspective in favor of a preventive, population-focused strategy. Third, it rejects an office bound mode of service delivery replacing it with an active, seeking mode. Finally, the SC paradigm, while recognizing the relevance of socialization and individual change, stresses

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[1]Reviewing recent policy developments in community mental health, Kuramoto (1977) concludes: "The present trend seems to be that the so-called "medical model" is on the rise because of the financial incentive in third party reimbursements which require medical services and programs that are devoted to remedial, medically-oriented services (p.400)."

the importance of making social institutions more responsive to individual and community needs.

Practice Knowledge and Manpower Issues

The SC paradigm offers an alternative to the medical paradigm and opens the door for the development of practice models based on a different set of values and assumptions. By far the most important breakthrough resulted from Caplan's (1964, 1970) efforts to apply public health concepts to the field of mental health. The widespread acceptance of Caplan's models, particularly client-centered and consultee-centered case consultation, attests to the impact of his work in CMHCs.

More recently, other approaches have emerged. The discovery of social support systems has renewed interest in prevention and suggested new ways for professionals to collaborate with community groups in promoting mental health (Caplan, 1974; Collins and Pancoast, 1976; Hurvitz, 1976). Similarly, the application of educational strategies to increase personal competence and problem solving suggests new directions for C&E practice (Berck, 1976; Cowen, 1977; Sanford, 1972).

In addition to the above developments, there is an indication C&E is gradually drawing on models from outside of the mental health field. Thus Gelfand (1976) argues that a planned change perspective offers an appropriate strategy for consultation practice. Similarly, See and Mustian (1974) present a sociological model of consultation, while Brennan and Todd (1976) combine mental health consultation and organization development within an ecological framework. Finally, strategies from community organization and social advocacy have been offered as appropriate tools for promoting community and organizational change (Heller and Monahan, 1977; Rappaport, 1977).

Although new practice models are being developed, there is a gap between theory and practice, between the development of new models and their application in practice settings. For example, the bulk of CMHC professionals, even those performing C&E roles, continue to function from a narrow knowledge base, drawing on clinical theory rather than public health or planned change perspectives. Lamenting this fact, Moed and Muhich (1972) observe:

> Mental health professionals are trained on heavy diets of medicine, psychology, and folklore. Typically, they know little about the organizational structure of agencies; not to speak of the political structure of government (Moed and Muhich, 1972, p.233).

To a large extent the discrepancy between theory and practice is perpetuated because major training centers, such as schools of social work and departments of psychology, continue to expose students to traditional models of service delivery. Ironically, in community psychology, where presumably students are exposed to alternative models, both the small number of students admitted and the length of the training required limit the availability of trained manpower for C&E.

One indication of the need for training in C&E can be found from our study of four C&E units (Dade and Strumwasser, 1977). When CMHC respondents (N=58) were asked to identify factors inhibiting C&E's development, the responses were grouped into seven categories with the largest percentage (19.5% or 25 responses) clustered under the heading lack of C&E knowledge, training, and skills. C&E directors in our sample also indicated a second problem: recurrent difficulty in recruiting staff with prior training or experience in C&E. Again, this reflects the unavailability of manpower trained in models of practice required to carry out complex, system level intervention.

Federal Policy and C&E

In an important and provocative article, Snow and Newton (1976) attribute the neglect of C&E services to the "professional and organizational structures" that originally determined and continue to shape the priorities of CMHCs. Snow and Newton argue that the CMHC movement's apparent shift toward a preventive ideology was an illusion, part of the "collective imagery of the 1960's." Drawing on Snow and Newton's analysis, the present paper examines the adequacy of federal guidelines and financial support for C&E programs.

Federal guidelines. From 1963 when CMHCs were first established until the passage of the 1975 CMHC Amendments (PL 94-63), federal guidelines for C&E were minimal, consisting of the broad mandate to extend direct services, to prevent mental illness, and to promote mental health. How these goals were to be achieved and what standards should be employed in implementing services were not addressed.

Although the absence of guidelines permitted local innovation, more often it led to the gradual erosion of C&E resources and staff (Cherniss, 1977; Moed and Muhich, 1972). To illustrate, we discovered that prior to PL 94-63, the C&E units in our sample were grossly understaffed, functioned without program coordinators, and seldom exhibited a coherent philosphy or set of goals. Equally important, we observed that C&E staff (1) were not represented in center-wide decision-making, (2) were frequently used as an "arm of the administration," and (3) were vulnerable either to having their roles redefined or their positions taken over by direct services.

While the new federal guidelines (PL 94-63) do not address these problems directly, they do provide a level of specificity not found in previous legislation. To begin with, the new guidelines require C&E programs

to be organized into a separate unit, coordinated by a professional worker. In addition, the guidelines authorize C&E (1) to assess community needs as a basis for setting C&E priorities; (2) to establish and maintain linkages with a variety of formal and informal caregiving systems; (3) to develop programs to promote mental health and prevent mental illness; (4) to initiate programs in rape prevention; and finally, (5) to monitor and evaluate C&E services.

Our findings indicate that these new guidelines are having a significant impact on the development of C&E programs.[2] Specifically, we have noted: (1) increased efforts to document C&E services; (2) increased autonomy for C&E relative to CMHC directors; (3) greater participation in center-wide decision-making; and (4) improved capacity to retain C&E positions in the face of demands for direct services.

Despite the aforementioned developments, more direction is needed before C&E can overcome years of neglect. Specifically, the following questions need to be answered:

(1) What is the minimum number of staff required to develop a viable C&E program?

(2) How much autonomy should C&E units have from center directors?

(3) What collaborative arrangements should be established between C&E units and evaluation components?

(4) What collaborative arrangements should be developed between C&E and clinical staff who spend a portion of their time performing indirect services?

(5) What are the range and types of C&E services that should be provided?

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[2]One respondent commented that PL 94-63 guidelines "brought C&E out of the dark ages."

Unfortunately, the above questions cannot be answered merely by issuing further guidelines, unless such guidelines are based on increased knowledge about the nature and goals of C&E services. Knowledge of this sort has to be acquired through research designed to increase our understanding about C&E's role and effectiveness within larger CMHC systems.

Financial support. A second policy issue concerns the adequacy of financial support for C&E programs. In the past, C&E has been supported through federal funds allocated for required CMHC services. However, the advent of third party payments, the gradual withdrawal of federal support for CMHCs, and the increasing role played by state governments whose commitment to C&E is unknown highlight the need to establish an independent base of support for C&E services. Recognizing this need, the Congressional committee reviewing 94-63 legislation stated that:

> "Support for consultation and education services beyond the period for which support is offered for general purposes has been included in the law by the Committee because it realizes that payment for such services is not generally available to the center under third party reimbursement plans or other sources of financing, and because the services are an integral part of comprehensive community mental health programs...
>
> (House Report No. 94-192, accompanying HR 4925, p.115).

Despite legislative intent, Congress approved only 10 million dollars for 1976 C&E programming, while the actual appropriation amounted to only four million. This sum, relative to the real need, raises questions about the federal government's commitment to C&E. Commenting on the effect of the 1975 legislation, Snow and Newton (1976) state:

> Consistent with our analysis, the new financial support for indirect services is comparatively small and conforms to the continuing pattern of clinical service dominance. Moreover, the list of essential clinical services has been lengthened, which has the effect of deepening the subordination of consultation and education. The forces--professional, organizational, and financial--against a basic change in task priorities of the CMHC are massive (p.592).

So far, we have identified three socio-political factors affecting C&E programs: the dominance of the medical paradigm; the unavailability of manpower trained in an alternative paradigm; and the inadequacy of federal guidelines and support for C&E services. These factors interact to restrict the flow of knowledge and material resources into local C&E programs. The next section focuses on factors affecting the development and delivery of C&E services at the local level. This analysis will draw heavily on archival records, field observations, and interviews from our current study of C&E units in four comprehensive CMHCs (Ketterer and Perkins, 1977; Bader and Dade, 1977; and Ketterer and Bader, 1977).

MICRO-ENVIRONMENT: COMMUNITY, ORGANIZATIONAL, AND PERSONAL FACTORS

While macro level variables set the parameters of C&E service delivery, micro-environmental factors also affect C&E programs. These factors shape the delivery of C&E services and account for variation in the nature and scope of these services. The following variables are viewed as having an important effect on C&E programs at the local level: (1) the community context; (2) CMHC director's knowledge and ideology; (3) CMHC organizational variables; (4) C&E leadership; and (5) information system/evaluation capacity.

Community Context

One of the most important yet least understood factors affecting C&E is how catchment areas (communities) influence the development and delivery of C&E programs. A major problem here is defining the term community. Does community refer (1) to an entire catchment area (between 150,000 and 200,000 people), (2) to smaller territorial units such as neighborhoods, or (3) to cultural communities such as ethnic and religious groups?

A second, related problem is that the demand for C&E services is limited and sporadic. Community populations seldom initiate requests for indirect services unless they have previously experienced the benefits of consultative or preventive interventions. This observation is consistent with Broskowski's (1974) point that individuals "without a current 'illness' are seldom interested in prevention activities and those who have an illness are more interested in treatment services" (p.715).

Although the above issues pose serious problems, and limit the impact of the community on C&E, our research indicates that communities have an indirect effect as a result of the sensitivity of C&E staff to community issues. Part of this sensitivity can be attributed to the fact that when C&E units recruit new members, they typically use community variables, such as ethnic background and experience working in the community, as important criteria in selecting staff. We also found that the way staff perceive community needs influences how they set C&E goals and priorities. Thus when C&E and CMHC staff (N=25) were asked to name two factors most influencing C&E's stated goals, federal guidelines were most frequently mentioned followed by community needs and staff knowledge/preferences.

A third indication of C&E's commitment to the community is that center directors in three of the four centers in our sample designated C&E staff to be liaisons to policy and advisory citizen boards. Liaison functions typically involve a range of consultative services to board members as well as the exchange of information regarding critical issues and events in the community.

The above findings, though preliminary, suggest three related propositions: (1) that C&E staff are selected because of their special knowledge or experience in the community; (2) that C&E staff are more

likely than other CMHC personnel to take community factors into account in delivering services; and (3) that expectations on the part of other CMHC personnel, particularly center directors, reinforces C&E's commitment to the community. The last proposition suggests that an important function of C&E units is to serve as a linking mechanism between mental health professionals and a variety of individuals and groups in the community.

CMHC Directors' Knowledge and Ideology

Organizational theorists have recently noted that human service agencies are characterized by ambiguous goals, indeterminate technologies, and the lack of valid and reliable measures of effectiveness (Hasenfeld and English, 1974; Ozanne, 1977). These deficiencies have led some observers to assert that human service organizations represent relatively underdeveloped organizational forms. According to Ozanne (1977), the undeveloped nature of human services tends to increase the influence of the chief executive such that the welfare of the agency and that of the chief executive are intertwined. Our findings support this claim and indicate that within the constraints placed on them by outside sources, CMHC directors have enormous discretion in setting program priorities, in allocating scarce resources, and in defining the center's overall goals and mission.

With respect to C&E, two aspects of the director's role appear to be of special importance. The first concerns the director's (and/or assistant director's) personal ideology toward mental health/mental illness, while the second concerns his/her knowledge about C&E services. When CMHC directors support C&E on ideological grounds and are knowledgeable about C&E services, there is a greater likelihood that C&E will receive the financial and administrative support it needs. For example, in our sample, the CMHC director who allocated the largest proportion of the CMHC budget

to C&E was both the most knowledgeable about C&E and expressed the strongest ideological support for C&E services.

Finally, an important caveat deserves mention: although ideology and knowledge often correlate, this is not always the case. To illustrate, we discovered that although the CMHC director in one center expressed a strong commitment to C&E, neither his formal training nor his experience equipped him to provide the C&E staff with the knowledge and direction needed to implement a successful C&E program. In this instance, ideology and commitment were not enough; knowledge and experience were also required to give an inexperienced C&E staff the support they needed.

Organizational Variables

In addition to leadership factors, organizational factors also affect C&E programs. One important factor concerns C&E's position within the center's organizational structure. Specifically, we found that prior to 94-63 guidelines, C&E was either part of central administration, functioning as an "arm of the administration," or was decentralized along outpatient lines with no central administrative plan for indirect services. In the first instance, C&E services were often displaced by CMHC administrative demands, while in the second case C&E services were fragmented, and functioned without a coherent philosophy or set of goals. In both instances, C&E services tended to lack (1) center-wide visibility; (2) adequate input into center-wide program decision-making; and (3) the power to negotiate for additional resources.

Because our study took place while C&E units were responding to 94-63 guidelines requiring them to organize into administrative units, we were able to observe how this new structure rectified many of the difficulties noted above. For example, prior to the development of the new guidelines,

only one center participated in center-wide decision-making. Now, more than a year later, all of the C&E programs take part in program decision-making within their respective agencies. Moreover, we have observed that once C&E programs were organized into administrative units, they increased their visibility within the CMHC, made progress in defining C&E goals, and protected C&E positions against encroachment due to demands for direct services.

A second organizational factor affecting C&E concerns whether a CMHC has administrative control over required programs such as outpatient and crisis services. Specifically, our findings suggest that C&E staff can more easily develop collaborative relationships with treatment staff when they are both part of the same administrative structure. For example, in several of the centers we studied, outpatient agencies operating from a different administrative structure (contract agencies) resisted efforts on the part of C&E staff to build collaborative relationships, creating difficulties beyond those normally associated with C&E programming. These resistances can be attributed to a number of factors, including distrust of C&E's proximity to central administration and resentment because C&E staff were not attached to the outpatient units. In two of these centers, the CMHC central administration later terminated the outpatient contracts and developed their own outpatient services. In both instances, C&E staff reported that with the change in structure it was easier to develop and sustain working relationships with direct service staff in decentralized outpatient units.

C&E Leadership

Our research reveals that C&E coordinators play a critical role both in the development and delivery of C&E services. Specifically, we have

noted that C&E coordinators: (1) recruit and train staff; (2) determine decision-making norms within the unit; (3) play a major role in shaping C&E program priorities; (4) negotiate with the CMHC directors for resources and staff; (5) educate other CMHC coordinators and staff to the purposes and goals of the C&E unit; and (6) develop linkages to knowledge and resource systems outside the C&E or CMHC system. Because the ultimate success of a C&E unit requires the C&E coordinator to carry out the above tasks, it is important to identify the role requirements and competencies needed to accomplish these tasks.

As in the case of CMHC directors, our findings suggest that the greater a C&E coordinator's commitment to and knowledge about C&E services, the greater the likelihood he/she will successfully carry out the critical tasks outlined above. For example, we observed that coordinators who had had previous training and experience in C&E were in a much better position than others to (1) define C&E goals; (2) articulate C&E's role in the CMHC; and (3) negotiate with CMHC directors for additional resources and support. Conversely, in centers where C&E coordinators lacked commitment, knowledge, or both, they were unable to provide the substantive input and motivation to sustain a viable and productive C&E unit.

A second, crucial dimension of C&E leadership has to do with the coordinator's level of interpersonal skills and competence. As the literature on leadership amply demonstrates, successful leadership requires more than technical expertise; it also requires the ability to deal effectively with interpersonal and process issues (Bowers and Seashore, 1966). Although this finding is applicable to a variety of settings, it is of special relevance in C&E, since C&E staff are required to work collaboratively in planning and implementing complex interventions. In this context,

the C&E director can demonstrate effective leadership by promoting open communication and trust and by developing procedures which reinforce individual growth while maintaining the achievement of stated C&E goals.

Information System/Evaluation Capacity

A final factor affecting C&E concerns its lack of an adequate information system and evaluation technology (Hagedorn et al., 1976; Bader and Ellsworth, 1977). This deficiency is well documented in the literature and is supported by our findings which indicate that:

(1) There are no standard definitions of C&E services or an agreed upon list of important dimensions of service.

(2) There is little continuity in data collection.

(3) Emphasis is placed on counting activities rather than measuring effectiveness.

(4) Procedures ensuring that forms are filled out accurately and on time have not been developed.

(5) Current data are not fed back to staff.

(6) Standardized forms do not exist, so information from different centers cannot readily be compared.

Although the deficiencies outlined above reflect C&E's overall lack of development, they also pose special problems for local C&E units. Specifically, the absence of an adequate evaluation technology prevents C&E staff not only from monitoring their own services, but also from communicating the nature and results of their work to relevant groups both inside and outside the CMHC. Fortunately, as Bader and Ellsworth (1977) report, efforts to develop information systems and evaluation procedures are currently taking place.

In the present context, a critical task not yet addressed involves developing a heuristic model specifying how the factors discussed in this paper are causally related. Using a general systems framework, the final section addresses this important issue.

FACTORS AFFECTING C&E SERVICES: TOWARD A CAUSAL MODEL

In the preceding sections, we identified a number of factors affecting the development and delivery of C&E services. This section presents a preliminary model specifying the causal relationships between the factors identified throughout the analysis. One reason for presenting such a model, however tentative, is that it will help elicit alternative views of how different factors interact and impinge on C&E programs. A second rationale for the model is that hypothesizing causal relationships will highlight areas in need of further research. For example, some investigators may choose to study the relationship between manpower issues and federal policy while others may want to examine how community, organizational, or interpersonal variables affect the provision of C&E services. Ultimately, we anticipate such study will result in an integrated model that can serve as a basis for improving the efficiency and effectiveness of C&E services.

As a step in this direction, our research suggests the preliminary model depicted in Figure 1. In this schema, socio-political factors--such as legislative guidelines and the prevailing mental health ideology--are seen as affecting the expertise and orientation of the CMHC director. The director influences the staffing of the CMHC and the C&E unit, and determines the organizational arrangements which are adopted. In addition, factors in the community combined with C&E staff perception of community needs influence the formulation of C&E service goals. C&E goals are also affected by the level of expertise of the C&E staff whose skills, in turn, are influenced by the prevailing state of knowledge in the macro-environment.

It is important to note that as yet little is known about C&E outputs, that is, about the nature and scope of services and their effects on diverse community systems (Mannino and Shore, 1975). Here C&E faces two major obstacles.

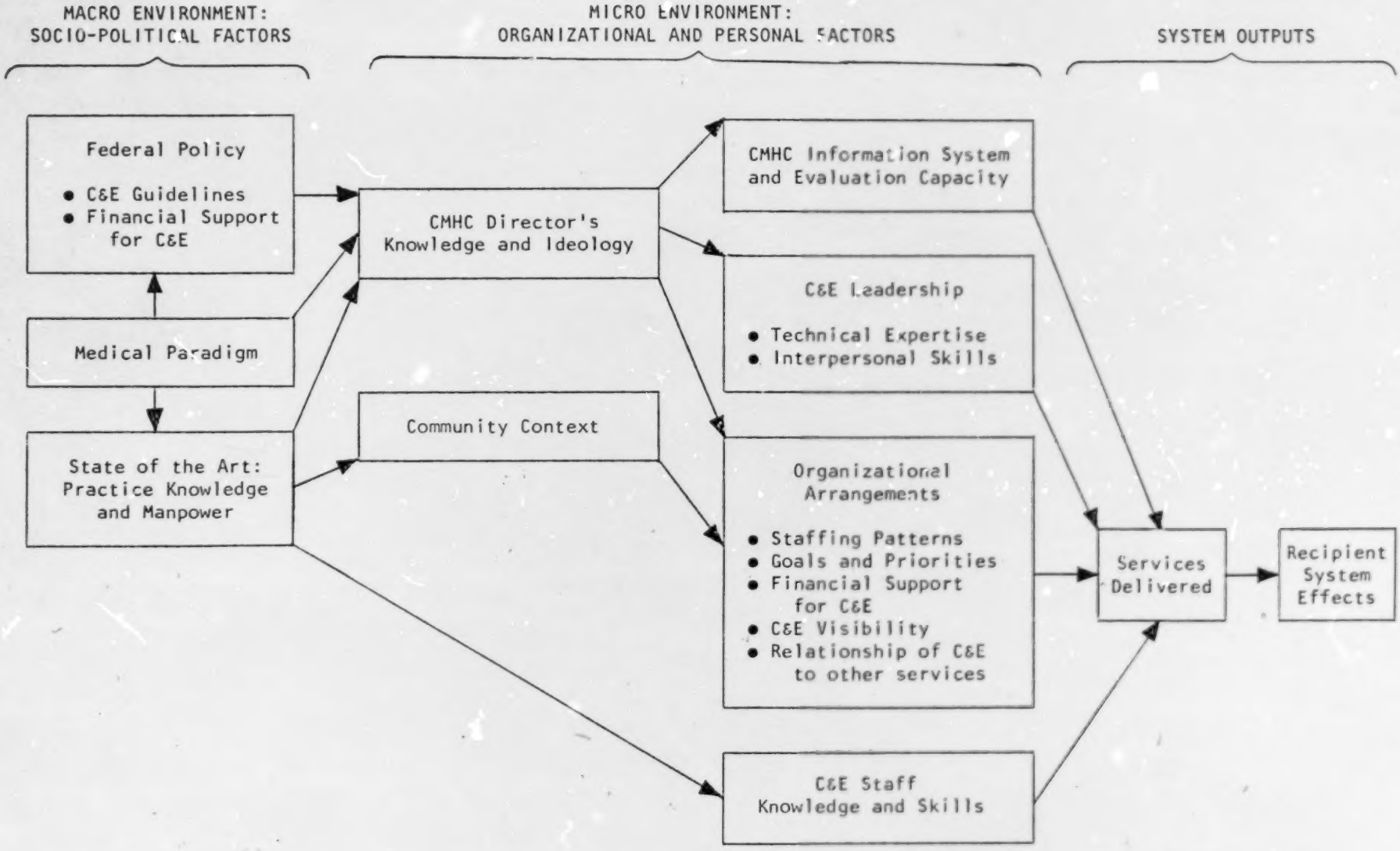

Figure 1 A preliminary model of factors affecting consultation and education programs.

The first is that C&E lacks the "consistency of procedure and method necessary for the experimental validation of effectiveness" (McClung and Stunden, 1970). A second, related problem is that C&E's complex and changing nature has hampered the development of ways of classifying C&E activities (Bader and Ellsworth, 1977). These obstacles highlight the need to generate descriptive knowledge about the nature, scope, and dimensions of C&E services.

Partly because of this lack of knowledge heuristic devices must be developed to help in conceptualizing factors affecting C&E services. In this context, our model is presented not only as a means of stimulating further discussion about C&E, but also as a starting point for defining future research and action in this important but neglected field of mental health service delivery.

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